WMA DECLARATION OF BERLIN ON RACISM IN MEDICINE

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PREAMBLE

Racism is rooted in the false idea that human beings can be ranked as superior or inferior based on inherited physical traits. This harmful social construct has no basis in biological reality; however, racist policies and ideas have been used throughout history and are still used to perpetuate, justify, and sustain unequal treatment.

Despite the fact that races do not exist in the genetic sense, in some cultures racial categories are used as a form of cultural expression or identity, or a means of reflecting shared historical experiences. This is one aspect of the concepts of "ethnicity" or "ancestry".

Acknowledging that the words "race" and "racial" have different connotations in different linguistic and cultural contexts, these terms are used throughout this document to denote socially constructed categories and not a biological reality.

While the false conflation of racial categories with inherent biological or genetic traits has no scientific basis, the detrimental impact racial discrimination has on historically marginalized and minoritized communities is well documented. The experience of racism in all its forms – for example, interpersonal, institutional, and systemic – is recognized as a social determinant of health and a driving force behind persistent health inequities, as noted in the WMA Declaration of Oslo on Social Determinants of Health. These inequities can be compounded by other factors like national origin, age, gender, sexual orientation, religion, socioeconomic status, disabilities, and more. Individuals subjected to racism are often also affected negatively by other social determinants of health.

Racially motivated violence and overt bias, housing and employment discrimination, education and health care inequity, environmental injustice, daily microaggressions, pay gaps, and the legacy of intergenerational trauma experienced by those who are subjected to racism are just some of the many factors that may impact health and illustrate why racism poses a serious threat to public health. These and other structural barriers faced by historically marginalized communities can lead to disproportionate rates of infant and maternal mortality and certain illnesses, mental health struggles, poorer health outcomes, as well as shorter life expectancies.

Racism in medicine

With the WMA Declaration of Geneva, the Physician's Pledge, the physician vows to respect the dignity of all patients, to respect teachers, colleagues, and students, and to "not permit considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor to intervene between [the physician's] duty and [the] patient."

Nonetheless, racism in all its forms also exists in medicine throughout the world and has a direct impact on patients and their health. Systemic racial disparities in access to care and health resources at a global and local scale can translate to disparities in health outcomes.

At the interpersonal level, prejudice and stereotypes held and acted upon by medical professionals can lead them to be reluctant to see patients or dismissive of symptoms from patients from marginalized communities, which can result in suboptimal communication, as well as inappropriate or delayed treatment. Racism can hinder or undermine the foundation of trust that is essential to a successful patient-physician relationship.

Physicians from marginalized communities also face racism from patients, other physicians, and health

professionals. This can take the form of bullying, harassment, and professional undermining in the workplace. These distressing experiences may not only impact the physician's health and well-being, but consequently the physician's performance. They may also leave marginalized physicians less confident to raise concerns about patient safety for fear of being blamed or suffering adverse consequences. Large and growing racial disparities in adequate professional treatment and advancement opportunities can have an impact on physicians' career trajectories.

Furthermore, systemic racism can create barriers to entry to the medical profession for certain historically excluded groups, leading to a lack of representation, which may contribute to adverse health outcomes for patients. These barriers are caused by a variety of factors, including implicit and explicit bias in admissions and hiring practices, a dearth in inclusive professional environments, and lifelong racial disparities in educational funding.

A medical profession that is representative of the population is crucial to addressing health disparities among patients.

Racism in medical education

In medical education, implicit and explicit bias not only impact the admissions process, but also the curriculum, faculty development, and how marginalized students are treated and assessed. Non-inclusive and harmful learning environments can leave minoritized students with an increased risk of anxiety and depression. In addition, learning materials and curricula often do not reflect a diversity of experiences, imagery, and disease presentations and fail to address the issue of racism in medicine head-on.

Racism in medical research / medical journals

Structural racism also influences participation and therefore inclusivity in medical research. Historical examples of unethical experimentation or research in the absence of informed consent on marginalized communities have led to a high level of mistrust of the medical establishment. On the other hand, exclusion of marginalized groups from clinical trials results in a lack of data about how certain drugs, treatments, or health conditions might impact individuals in those groups. A lack of racial data transparency can lead to a lack of understanding about how racial disparities lead to health inequities. It can also jeopardize the potential of artificial intelligence to reveal and override biases in medicine. Algorithms are only as inclusive as the health and technology professionals who create them.

Furthermore, medical journals – the gatekeepers of evidence-based research – have generally been remiss in addressing the issue of racism and its impact on health inequities, as well as in addressing underrepresentation among journal decision makers and authors.

DECLARATION

Therefore, the World Medical Association

- condemns unequivocally racism in all its forms and wherever and whenever it occurs;
- declares racism to be a public health threat;
- acknowledges that racism is structural and deeply engrained in health care;
- asserts that racism is based on a social construct with no basis in biological reality and that any effort to claim superiority by exploiting racist assumptions is unethical, unjust, and harmful;
- recognizes that the experience of racism is a social determinant of health and responsible for persistent health inequities;
- commits to actively promote equity and diversity in medicine and to strive for an inclusive and equitable health environment.

RECOMMENDATIONS

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The WMA urges its members and all physicians to:

1. enact the above-mentioned declaration in their own organizations;
2. acknowledge the harmful impact of racism on the health and well-being of marginalized communities and act upon it;
3. promote equitable access to health and other societal resources locally, nationally and on a global scale;
4. commit to actively work to dismantle racist policies and practices in health care and advocate for antiracist policies and practices that support equity in health care and social justice;
5. implement organizational and institutional changes to foster diversity in the medical profession and the organizations that support it;
6. support and, where possible, implement admissions and curriculum changes in medical education that promote inclusivity and raise awareness about the harmful impact of racism on health;
7. promote just and safe learning environments in medical education;
8. promote equitable access to quality medical and public health education;
9. center the experiences of physicians from underrepresented communities to ensure the visibility of role models and foster a feeling of inclusivity and empowerment among prospective students from historically marginalized communities;
10. ensure safe, supportive, and respectful work environments for all physicians, including those from historically marginalized communities;
11. establish channels for physicians and students of medicine to safely report cases of racially motivated harassment or bias;
12. enact disciplinary measures against perpetrators of racial harassment or bias in the medical profession and implement measures to prevent such harassment and discrimination, to protect those who suffer from it and to eliminate it from the medical field;
13. take measures to identify research gaps and promote evidence-based research on the health impact of racism;
14. encourage medical journals to amplify the voices of medical researchers and health experts from underrepresented and historically excluded communities;
15. make all efforts to promote representation in ethically conducted clinical trials in accordance with the WMA Declaration of Helsinki as a means of advancing health equity;
16. promote further research on the impact of racism in the health system.